

TWIN II

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02849

## CERTIFICATE OF DEATH

1 lt. 10 107 02842

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Route 2 Box 248</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy ARMSTRONG</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	9. AGE (In years last birthday) <u>5</u> yrs. <u>37</u> Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Schoolfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Evelyn S. Armstrong</u>		Address <u>Pocomoke, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 700 gms)</u> DUE TO (b) <u>approx 5 min</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>approx 5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>67</u> to <u>4/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C. Kells</u>		22b. DATE SIGNED <u>2/20/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Meth. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>
24. FUNERAL DIRECTOR <u>Thurmond Sargent</u>		25a. REC'D BY REGISTRAR <u>New Church, Va.</u>	
25b. REGISTRAR'S SIGNATURE <u>g Charles Jones</u>		DATE <u>FEB 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23850

3230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Maryland State Department of Health														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
Baby I 02850					CERTIFICATE OF DEATH					02843				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>					d. STREET ADDRESS <u>Route 2 Box 248</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Route 2 Box 248</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Baby Girl Armstrong</u>					4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1967</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Feb. 20, 1967</u>		9. AGE (In years last birthday) yrs. <u>7</u> <u>50</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>30</u> Min.		IF UNDER 24 HRS. Hours <u>30</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Armstrong</u>					14. MOTHER'S MAIDEN NAME <u>Evelyn Schoolfield</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>776X</u>		17. INFORMANT <u>Evelyn S. Armstrong Pocomoke, Md.</u>				Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birthwt 670 gms)</u> DUE TO (b) <u>apnea</u> DUE TO (c) <u>2 1/2 hrs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>apnea</u> <u>2 1/2 hrs</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>67</u> , to <u>2/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> 19 <u>67</u> and that death occurred at <u>7:52</u> M, from causes and on the date stated above.														
22a. SIGNATURE <u>Arthur C. Keller</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED <u>2/20/67</u>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Meth. Cem. Pocomoke</u>			23d. LOCATION (City or Town) (County) (State) <u>Wor. Md.</u>						
24. FUNERAL DIRECTOR <u>Samuel S. Sams</u>					ADDRESS <u>New Church, Va.</u>					25a. REC'D BY REGISTRAR DATE <u>FEB 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

7-23017-3

05849

CERTIFICATE OF DEATH

05850

INFORMANT (Name and Address)

1911

1911

1911

1911

1911

1911

1911

1911

1911



02851

## CERTIFICATE OF DEATH

04362

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>22-1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury Fruitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Morris Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>AYRES</b>			4. DATE OF DEATH Month Day Year <b>February 27 1967</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 22 1927</b>		9. AGE (In years last birthday) yrs. <b>39</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Isaac Ayres</b>		14. MOTHER'S MAIDEN NAME <b>Baulah</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Baulah Ayres Fruitland Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity - 465 gms</b> 776X DUE TO (b) <b>Premature</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <b>8:20 P.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>William C. Morgan</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/4/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church</b>	
23d. LOCATION (City or Town) (County) (State) <b>Taylor Gate Md.</b>		24. FUNERAL DIRECTOR <b>Clinton F. Stewart</b>		25a. REC'D BY REGISTRAR <b>MAR 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04365

ESTIMATE OF DEATH

02881

General Hospital

WFO

4 1 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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80

3

1

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02852

## CERTIFICATE OF DEATH

02844

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN Tb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>305 East 4th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alfred John Bailey</b> First Middle Last 4. DATE OF DEATH <b>February 14 1967</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 1, 1913</b> 9. AGE (In years last birthday) <b>53</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Laurel, Delaware</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Bailey</b> 14. MOTHER'S MAIDEN NAME <b>Sallie Nichols</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>221-09-4350</b> 17. INFORMANT <b>Mrs. Grace D. Bailey, 305 East 4th Street, Laurel, Delaware</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism suspected</b> <b>466X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Phlebotrombosis rate undetermined</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1 Cause of Death - pulm. embolism (2) Rheumatoid arthritis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>01-28</b> , 19 <b>67</b> , to <b>02-14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>02-14</b> 19 <b>67</b> , and that death occurred at <b>5:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph C. F. [Signature]</b> 22c. PHYSICIAN'S NAME (Type) <b>Medical Center</b>		22b. DATE SIGNED <b>2-14-67</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2-16-67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Near Preston, Maryland</b>		24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Md.</b> 25a. REC'D BY REGISTRAR <b>FEB 20 1967</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

02834

GENERAL HOSPITAL

02833

Allegation

Allegation

General Hospital

100

02853

## CERTIFICATE OF DEATH

02845

1. PLACE OF DEATH a. COUNTY <u>Wicomico County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u> <u>22-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>BAKER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 31, 1890</u>		
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Truck</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Slidell Baker</u>				14. MOTHER'S MAIDEN NAME <u>Anna Jane Donaway</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-22-7691</u>		17. INFORMANT <u>Everett Baker Pittsville, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema.</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>BronchoPneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>7 years</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>February 13, 1967</u> , to <u>February 24, 1967</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>February 24, 1967</u> , and that death occurred at <u>11:50 A.M.</u> from causes on and on the date stated above.								
22a. SIGNATURE <u>C. H. Winnacott</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/24/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. H. Winnacott</u>				22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/26/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pittsville, Maryland</u>		
24. FUNERAL DIRECTOR <u>Charles Judge - Salisbury, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05803

DEPARTMENT OF HEALTH

05803

188 13 117

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02854

## CERTIFICATE OF DEATH

02846

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevensville</b> 17.2	
c. LENGTH OF STAY IN lb <b>33 days</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Luther</b> Middle <b>Thomas</b> Last <b>Baxter</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27-1887</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>17</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Baxter</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Frampton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>418-12-10024</b>	
17. INFORMANT <b>Mrs. John Nash--Chester, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Broncho - Pn.</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>10-14 days</b> <b>--</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Thrombosis with right Hemiplegia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 24, 1967</b> , to <b>Feb. 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 26, 1967</b> , and that death occurred at <b>9 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Winnacott</b>		22b. DATE SIGNED <b>2-26-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 28</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville</b>		23d. LOCATION (City or Town) (County) (State) <b>Stevensville, Md.</b>	
24. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05848

05848

MAR 2 1967

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02855

## CERTIFICATE OF DEATH

02847

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>3 Wks.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>306 N. Div. St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE JULIA BERRY</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 2 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sales Lady</b>	11. BIRTHPLACE (County & State, or foreign country) <b>N.C.</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-0907</b>	17. INFORMANT <b>Mr. E.R. White Jr. Park Ave. Salisbury, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Years</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebrovascular Accident</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 16, 1967</b> , to <b>February 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>February 1, 1967</b> , and that death occurred at <b>5:39 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas P. Bigbee</b>		22b. DATE SIGNED <b>Feb. 2, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas P. Bigbee</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-5-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Episcopal Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke, Maryland</b>
24. FUNERAL DIRECTOR <b>Hille Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 7 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Alomico General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02856

# CERTIFICATE OF DEATH

02848

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Lane, Fruitland 221</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Bivans</b> Last <b>Bivans</b>						4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1967</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 1895</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pocomoke Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>SARAH HUTT</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Phillip H. H. - Cedar Lane Fruitland, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HTASCVD</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>Unk.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> , 19 <b>66</b> , to <b>2/12</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/12</b> , 19 <b>67</b> , and that death occurred of <b>7:30</b> P.M. from causes on and on the date stated above.															
22a. SIGNATURE <b>George A. Henning</b> M.D.										22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>				23d. LOCATION (City or Town) (County) (State) <b>St. Paul Office Somers, Md.</b>							
24. FUNERAL DIRECTOR <b>Arletta S. Jolley - Jolley &amp; Son, Salisbury, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

32850

02850

1102116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02857						02849					
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				d. STREET ADDRESS <b>205 Powell Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mary Frances Bradley</b>						4. DATE OF DEATH Month <b>Feb.</b> Day <b>7,</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 10, 1893</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>John T. Green</b>						14. MOTHER'S MAIDEN NAME <b>Sallie Polk</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>217-03-7744</b>					
17. INFORMANT <b>Mr. Milton A. Bradley</b>						Address <b>205 Powell Ave. Salisbury, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO <b>Hypertensive cerebrovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Not known</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>1/31/67</b> to <b>2/7/67</b> that (I) (we) last saw the deceased alive on <b>1/31/67</b> and that death occurred at <b>6:25</b> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas F. Wallace</b>						22b. DATE SIGNED <b>FEB 9 1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Wallace</b>						22d. ADDRESS <b>Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>											
23b. DATE THEREOF <b>2-10-1967</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>											
23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas F. Wallace</b>											
25a. REC'D BY REGISTRAR <b>DATE FEB 9 1967</b>											
25b. REGISTRAR'S SIGNATURE <b>John J. Jones</b>											

03840

03251

CERTIFICATE OF DEATH

Charles A. Thompson  
Appointed as Clerk of the  
County of ...

1st of 1st

1st of 1st

CERTIFICATE OF DEATH

02858

02850

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>83-3</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Hallwood</b>			
3. NAME OF DECEASED (Type or print) <b>Marine Bull</b>		First <b>Marine</b> Middle <b>Good</b> Last <b>Bull</b>		4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 20, 1894</b>		9. AGE (In years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Nelsonia - Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Bull</b>		14. MOTHER'S MAIDEN NAME <b>Kitty T. Baker</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>225-01-7021</b>		17. INFORMANT <b>Mrs Marine Bull</b> Address <b>Hallwood Va</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 1600 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post operative Sanguine on oral Crutty</b> (c) <b>became of Coccarina 7 Rose C Aspiration</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/10/65</b> , 19__ to <b>9/22/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>9/22</b> , 19__, and that death occurred at <b>9:45 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Donald F. Fitcher Jr</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald F. Fitcher Jr</b>		22d. ADDRESS <b>Horsey, Va</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>2/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesleys</b>		23d. LOCATION (City or Town) (County) (State) <b>Wesleys Va</b>	
24. FUNERAL DIRECTOR <b>J. Richard Johnson</b>		ADDRESS <b>Parkburg, Va.</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03880

CENTRAL OF DEATH

03880

03880 03880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02853						02851					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>				d. STREET ADDRESS <u>RFD 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD 3</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>ISAAC</u> Last <u>CALLOWAY</u>						4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 30 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired trainman Penn, R. R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Isaac Merrill Calloway</u>						14. MOTHER'S MAIDEN NAME <u>Mary Virginia Phillips</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>717-07-8296</u>		17. INFORMANT <u>Martha Calloway Delmar Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral arteriosclerosis, encephalopathy</u> DUE TO (c) <u>5 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>aspiration pneumonia</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>Feb 3 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 2 1967</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>L.V. Sohler</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>L.V. Sohler</u>						22d. ADDRESS <u>Delmar, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Stephens</u>		23d. LOCATION (City, town or county) (State) <u>Delmar Del</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marcel Linnard Howe</u>						ADDRESS <u>Delmar Del</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

03821

CONFIDENTIAL

03821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Third parties remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02860

## CERTIFICATE OF DEATH

02852

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN lb			
NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>726 Westover Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Edward Saul Collins</u>				4. DATE OF DEATH <u>February 17 1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SNOW HILL, MD</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William Milbourne</u>				14. MOTHER'S MAIDEN NAME <u>SARAH COLLINS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>LAURA COLLINS - 726 Westover Dr. Salisbury</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis.</u> (c) <u>Acute Asthmatic Bronchitis; Emphysema.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 17, 1967</u> to <u>Jan. 17, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan. 17, 1967</u> and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. Herbert Sembly</u>				22b. DATE SIGNED <u>2/21/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly M.D.</u>				22d. ADDRESS <u>Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Wico - Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Loretta B. Jolley</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE				DATE <u>FEB 28 1967</u>			

02882

02882

735 Western Ave  
Gallatin  
Maryland

Edward Scott

11-11-1923

11.2

March 11, 1924

Gardner

Frank Collins

William Allborno

Frank Collins 735 Western Ave

March 11, 1924 - 12  
1923  
March 11, 1924  
1923  
March 11, 1924  
1923



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

02861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02853

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u> 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Peninsula General Hospital</u>		d. STREET ADDRESS <u>Richardson's Labor Camp</u>	
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>COLLINS</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 5, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		9. AGE (In years lost birthday) yrs. <u>61</u>	
11. BIRTHPLACE (State or foreign country) <u>P.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN JENNETT</u>		14. MOTHER'S MAIDEN NAME <u>James Collins Pittsville, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>231-10-0610</u>		16. SOCIAL SECURITY NO. <u>231-10-0610</u>	
17. INFORMANT <u>James Collins</u>		Address <u>Pittsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>491X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Notural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/30/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glass Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Pittsville, Md.</u>	
24. FUNERAL DIRECTOR <u>West</u>		25a. REC'D BY REGISTRAR <u>Mar 7 1967</u>	
ADDRESS <u>Un. Home, Salisbury</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

05830

05830

*Handwritten signature*

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A1SME (S)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02862

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02854

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>409 Lake St.</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>STANLEY</u> Last <u>COOK</u>		4. DATE OF DEATH Month <u>2-3</u> Day <u>67</u> Year <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17 - 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9. AGE (In years last birthday) <u>63</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Wetipiquin</u>
13. FATHER'S NAME <u>Joseph J. Cook</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>107-143539</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Redell</u>	
16. SOCIAL SECURITY NO. <u>107-143539</u>		17. INFORMANT <u>Robinson Edward Cook</u> Address <u>110 S. Small St - Salisbury</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
<u>409 Camden Ave., Salisbury, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-6-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Fellow</u>		23d. LOCATION (City or Town) (County) (State) <u>Wetipiquin Wicomico Md</u>	
24. FUNERAL DIRECTOR <u>Jolley Funeral Home, Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

BP 2

05824

05824

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02863					02855				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Wicomico</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
c. LENGTH OF STAY IN 1b <b>Adm. in 1 D 2/1/67</b>					d. STREET ADDRESS <b>226 Monticello Ave.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
<b>PAULINE KATHERINE</b>			<b>CULVER</b>			<b>February</b>		<b>2 1967</b>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<b>Female</b>	<b>White</b>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>Jan. 13, 1904</b>		<b>63 yrs.</b>	Months <b>0</b>	Days <b>19</b>	Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>(Unk.) Feuse</b>					14. MOTHER'S MAIDEN NAME <b>Freida Ott</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Wayne A. Culver (Son) 226 Monticello Avenue, Salisbury, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastatic carcinoma of colon</b> 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of colon</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>6 mo. 3 yrs.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May, 1963</b> , to <b>2/2/67</b> , that (I) (we) last saw the deceased alive on <b>2/2/67</b> , and that death occurred <b>at 12:05 A.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					22b. DATE SIGNED <b>Feb. 3 /1967</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. G. J. Burton</b>					22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bridgeville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bridgeville, Delaware</b>		
24. FUNERAL DIRECTOR ADDRESS <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>DATE B 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

5020

02950

(S) 10-10-68 - 10-10-68

Common of Japan  
Flowers white, sometimes pinkish



02864

## CERTIFICATE OF DEATH

02856

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>10 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> d. STREET ADDRESS <b>32 Greenway Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY JACKSON</b>		4. DATE OF DEATH <b>February 10 1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1921</b>
9. AGE (In years last birthday) <b>45 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Drug</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Jackson Custis, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Stanford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW 2</b>		16. SOCIAL SECURITY NO. <b>218-10-8059</b>	
17. INFORMANT <b>Mrs Beverly Custis, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary emboli, from phlebotrombosis</b> 466X DUE TO <b>Rt. leg.; Bilateral lower lobe pneumonia;</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2-3 days.</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>post-operative peritonitis; Rt. subhepatic abscess; duodenal fistula; gastric ulcer; colectomy</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/3, 1966</b> to <b>2/10, 1967</b> , that (I) (we) last saw the deceased alive on <b>2/10, 1967</b> , and that death occurred at <b>6:00 P.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>William P. Sadler</b>		22b. DATE SIGNED <b>2/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William P. Sadler</b>		22d. ADDRESS <b>Medical Center Salisbury, Wic, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-13-1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City Wor. Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert H. Watson</b>		DATE <b>FEB 17 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02884

02884

Wisconsin

Salisbury

Pennsylvania General Hospital

100-100000-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

02865

CERTIFICATE OF DEATH

02857

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>967 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>30 Edgewood Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Julius</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/82</b> 9. AGE (In years last birthday) <b>84</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Factory</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>266-18-069A</b>	
17. INFORMANT <b>E.K. Williams</b>		Address <b>4 Church ST Bridgeville, Del.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) <b>Arteriosclerotic cardio vascular disease</b> DUE TO <b>0382</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Lues, latent treated.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 22</b> , 1964, to <b>February 14</b> , 1967, that (I) (we) last saw the deceased alive on <b>February 14</b> , 1967, and that death occurred at <b>8:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Winnacott</b>		22b. DATE SIGNED <b>2-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. C. H. Winnacott</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Middleford Sussex Del</b>
24. FUNERAL DIRECTOR <b>Wm. A. Berry Jr - Milford, Del</b> <b>H.E. Hordesty &amp; Sons - Bridgeville, Del.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 17 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				d. STREET ADDRESS <b>683 Fitzwater St.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pinensula General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Clayton Dashiield (Deshields)</b>						4. DATE OF DEATH <b>Feb. 10 1967</b>						
5. SEX <b>M</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1890</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Dashiield</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes N.W.1</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Fulton Dashiield R.F.D.1 Hebron Md.</b>				Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO												
Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardiovascular Disease</b> <b>3 1/2 Years</b>												
(a), stating the underlying cause last. (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Salisbury</b>		(County) <b>Md.</b>		(State)	
21. I certify that (I) <del>(Michael)</del> attended the deceased from <b>4/6/63</b> to <b>2/1/67</b> , that (I) <del>(see)</del> saw the deceased alive on <b>2/1/67</b> , 19....., and that death occurred at <b>2:15M</b> , from the causes and on the date stated above.												
22a. SIGNATURE <b>Ivory U. Sully, Jr.</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/14/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Ivory U. Sully, Jr., MD</b>						22d. ADDRESS <b>P. O. Box 126, Berlin, Md. 21811</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/16/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>			23d. LOCATION (City, town or county) <b>Salisbury Md.</b>			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton F. Stewart</b>						ADDRESS <b>Salisbury Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION

02858

CONFIDENTIAL OF DEATH

02858

Immediate

Psychiatric Institution

34 years

Department of Corrections

2/10/50

2/10

2/10

2/10

F. O. Box 125, Boston, MA 02111

Tracy H. Smith, Jr., Esq.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02867					02859				
1. PLACE OF DEATH a. COUNTY <b>So Wicomico</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>Jesterville</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>			First Middle Last <b>W. DASHIELLS</b>		4. DATE OF DEATH <b>2/4/67</b>		Month Day Year <b>19 67</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Apr. 10, 1880</b>		9. AGE (In years last birthday) <b>86</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Jesterville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Dore Bailly</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>210-20-7865</b>		17. INFORMANT <b>Nathaniel Dasniellis</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma Prostate</b> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized Adenocarcinoma</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis - several years</b> INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1966</b> to <b>Feb. 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 24, 1967</b> , and that death occurred at <b>3:59 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>G. Herbert Semblly</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>2/6/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>G. Herbert Semblly</b>			22d. ADDRESS <b>Salisbury Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/8/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elzeys Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Jesterville Md.</b>			
24. FUNERAL DIRECTOR <b>Anthony E. Ward Crisfield Md.</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>FEB 8 1967</b>									

03250

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02868

CERTIFICATE OF DEATH

02860

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>6 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Rt. #1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>DONALD FRANCIS DUNNOCK</b>		4. DATE OF DEATH Month Day Year <b>2 27 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1893</b>
9. AGE (In years last birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>27 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland, Dorchester</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Matthias M. Dunnock</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-38-1081</b>	
17. INFORMANT <b>Mrs. Helen S. Dunnock, Sec 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-21</b> , 19 <b>67</b> to <b>2-27</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>2-27</b> 19 <b>67</b> , and that death occurred at <b>3:10 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Wilber R. Ellis, Jr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wilber R. Ellis, Jr., M.D.</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-1-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR <b>Hill Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

*Norman F. Baker*

05880

RECEIVED OF DEATH

88850

MAR 1 1961

FOR STATE HEALTH DEPT.

02869

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02861

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>804 E. Church Street</b>			d. STREET ADDRESS <b>804 E. Church Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>ELLIOTT, SR.</b>			4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 25, 1905</b>		9. AGE (In years last birthday) <b>61</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Window Cleaning Serv. Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>A. Lee Elliott</b>			14. MOTHER'S MAIDEN NAME <b>Mary Wright</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>159-03-2050</b>		17. INFORMANT (Address) <b>Mrs. Rada C. Elliott (Wife) 804 E. Church Street, Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epilepsy</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D.		22. DATE SIGNED <b>February 20, 1967</b>	
EXAMINER'S NAME (Type) <b>409 Camden Avenue, Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wicomico County, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*John H. ...*



02870

## CERTIFICATE OF DEATH

Items#8 &amp; 9 Film C286 3/10/67mb

02862

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAVRA</u>		First		Middle		Last <u>EVANS</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1967</u>		9. AGE (In years) <u>56</u> (lost birthday) Months Days Hours Min.	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Sept. 5, 1910</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Evans</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lucretia Evans, Accomac, Va.</u>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningeal Convulsion</u> DUE TO <u>K.C.U. Disease</u> DUE TO <u>Meningeal Cystitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Typhlophritis 1 month of non</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 22, 1967</u> to <u>Jan. 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1967</u> , and that death occurred at <u>10:45 M.</u> from causes and on the date stated above.		22a. SIGNATURE <u>G. Herbert Sembly</u> M.D.		22b. DATE SIGNED <u>2/26/67</u>		22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>		22d. ADDRESS <u>#89 E Church St. Salisbury, Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Accomac</u>		23d. LOCATION (City or town) (County) (State) <u>Accomac, Accomac, Va.</u>		24. FUNERAL DIRECTOR <u>Samuel Savage - new church, Va.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAR 2 1983

## CERTIFICATE OF DEATH

02871

02863

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>MANOKIN</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MANOKIN</b> d. STREET ADDRESS <b>19-2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lydia C. Fontaine</b>		4. DATE OF DEATH <b>February 16 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 16, 1875</b>
9. AGE (In years last birthday) <b>92</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>ALBANY, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CHAMBERLIN</b>		14. MOTHER'S MAIDEN NAME <b>CHRISTINA ROCKEFELLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>320-52-8939</b>	
17. INFORMANT <b>MISS VIRGINIA FONTAINE</b>		Address <b>MANOKIN, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>Cerebral aneurysm (basal ganglia)</b> DUE TO (b) <b>Intermittent hypertension</b> DUE TO (c) <b>Chronic atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>2</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> , 19 <b>67</b> , to <b>2-16</b> , 19 <b>67</b> (that (I), (we) lost saw the deceased alive on <b>2-16</b> , 19 <b>67</b> , and that death occurred at <b>7P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W. B. Wilson</b>		22b. DATE SIGNED <b>2-17-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/19/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MANOKIN PRES. CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCESS ANNE, MD.</b>	
24. FUNERAL DIRECTOR <b>LEVIN R. WILSON</b>		ADDRESS <b>PRINCESS ANNE, MD.</b>	
25a. REC'D BY REGISTRAR <b>DATE FEB 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Peninsula General Hospital

JAN. 15, 1965

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CHRISTIAN SOCIETY

CHRISTIAN SOCIETY

220-52-4050 MISS VIRGINIA MONTGOMERY

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MISS VIRGINIA MONTGOMERY

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02861

1 **M**  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Delmar</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NANCY S. FRANKLIN</b>		4. DATE OF DEATH Month <b>2-10-67</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-34</b>
9. AGE (In years last birthday) <b>32</b> yrs.		10. IF UNDER 1 YEAR Months <b>32</b> Days <b>32</b> Hours <b>32</b> Min. <b>32</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jesse Shortt</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Dickel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Jesse Shortt, Snow Hill, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1750</b> IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO (b) <b>Ovarian carcinoma</b> DUE TO (c) <b>months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>February 13, 1967</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 12, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spence Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Snow Hill, Maryland</b>
24. FUNERAL DIRECTOR <b>Dennis Funeral Home, Snow Hill, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>			

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*[Handwritten signature]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02873

CERTIFICATE OF DEATH

02865

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>22-1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>R.F.D.L Mardela Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILBERT Mc KINLEY GAINES</b>						4. DATE OF DEATH <b>FEBRUARY 15 19 67</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20, 1902</b>		9. AGE (In years last birthday) <b>64</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harrison Gains</b>				14. MOTHER'S MAIDEN NAME <b>Martie Truitt</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-8469</b>		17. INFORMANT <b>Martona Gaines R.F.D.1 Mardela Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Anteriosclerotic Heart Disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bleeding right lower leg</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> , 19 <b>67</b> , to <b>2/15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> , 19 <b>67</b> , and that death occurred at <b>10:20</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>David J. Gilmore</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/18/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Methodist</b>		23d. LOCATION (City or Town) _____ (County) _____ (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Clinton E. Stewart Salis Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

80

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02874

CERTIFICATE OF DEATH

02866

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN TB <b>Adm. in 1 D</b> <b>177/67</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ROBERT ALLEN GAMBRILL</b> First Middle Last 4. DATE OF DEATH <b>FEBRUARY 3 1967</b> Month Day Year			5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Oct. 1, 1896</b> 9. AGE (In years last birthday) <b>70</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Retired) Farmer</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Hebron, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James E. Gambrill</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War I</b> 16. SOCIAL SECURITY NO. <b>War I</b> 17. INFORMANT <b>Mrs. Minnie E. Gambrill (Wife)</b> <b>Mardela Springs, Maryland</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute lymphatic Leukemia</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic obstructive airway disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Part I or Part II at item 18.) <b>N/A</b> 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 25, 1966</b> to <b>Feb. 3, 1967</b> that (I) (we) last saw the deceased alive on <b>February 2, 1967</b> , and that death occurred at <b>10:30 A.M.</b> from causes and on the date stated above.			22a. SIGNATURE <b>Thomas P. Bigbee</b> M.D. 22b. DATE SIGNED <b>Feb. 3 /1967</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas P. Bigbee</b> 22d. ADDRESS <b>Maryland Avenue, Salisbury, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Feb. 6, 1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Memorial Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Mardela, Maryland</b>			24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b> 25a. REC'D BY REGISTRAR <b>FEB 6 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>		

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STATEMENT OF DEATH

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02875

## CERTIFICATE OF DEATH

02867

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs - Rural</b> d. STREET ADDRESS <b>San Domingo</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lettie Geneva GLAZE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1912</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	11. IF UNDER 24 HRS. Hours <b>6</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer - Marvil Package Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sharpstown, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-12-1421</b>	
17. INFORMANT <b>Dora M. Winfield, Wilmington, Del.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO (b) <b>HTASCVD</b> DUE TO (c) <b>Unk.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>18 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> , 19 <b>67</b> , to <b>2/7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/7</b> , 19 <b>67</b> , and that death occurred at <b>4 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>George H. Henning</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 11, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Zion Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Sharpstown, Maryland</b>	
24. FUNERAL DIRECTOR <b>J. J. Frampton</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>J. J. Frampton</b>		25c. DATE <b>FEB 16 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0880

UNITED STATES DEPARTMENT OF HEALTH

0880

Director

Secretary

Department of Health

June 1, 1911

Washington, D.C.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

W. H. C. [Signature]

Chief Clerk

Enclosure

Very truly yours,

W. H. C. [Signature]

Chief Clerk

Enclosure



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
02876		CERTIFICATE OF DEATH				02868				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN lb <u>LIFETIME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>MAIN ROAD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>WINNIE</u> Middle <u>HARRIS</u> Last <u>HARRIS</u>					4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>25</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 17-1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARETAKER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HUNTING LODGE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JABEZ</u>					14. MOTHER'S MAIDEN NAME <u>LOVENIA DAYTON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>MRS VIRGINIA OWENS - PRINCESS ANNE MD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>Not known</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus. Nephropathy &amp; leukemia</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/23/1967</u> to <u>2/25/1967</u> that (I) (we) lost saw the deceased alive on <u>2/24/1967</u> and that death occurred at <u>4A</u> M, from causes and on the date stated above.										
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/25/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>DEAL ISLAND Som MD.</u>				
24. FUNERAL DIRECTOR <u>Leroy Webster - Princess Anne</u>					ADDRESS <u>MD</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MAR 2 1961

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02869

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital D.O.A.</b>				d. STREET ADDRESS <b>Parker Ave., R.D.#3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOHANNA</b> Middle <b>(NMI)</b> Last <b>HELLINGER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 20, 1897</b>		
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b>		IF UNDER 24 HRS. Hours <b>4</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired -Chiropractor</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Karl Heinrich Koch</b>				14. MOTHER'S MAIDEN NAME <b>Emma Kessler</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>108-03-4643</b>		17. INFORMANT <b>Louis Hellinger (Husband)</b> Address <b>R.D.#3, Parker Ave., Salisbury, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crowning Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Butterfly Scarlet C. V. Hand</b> DUE TO (c) <b>Jan</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Jan</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
22. DATE SIGNED <b>February 25 / 1967</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Feb. 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lee's Sons Co.</b>		23d. LOCATION (City or town) (County) (State) <b>Washington, D. C.</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

02880

10-10-1961

10-10-1961

10-10-1961

02878

## CERTIFICATE OF DEATH

02870

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>R.F.D. 2</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willis Reynolds Howard</b>				4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 11, 1898</b>		9. AGE (In years last birthday) yrs. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Thomas Howard</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Miller</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>261-28-7654</b>		17. INFORMANT Address <b>Mrs Bertha C. Howard, Pocomoke, Md.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Disease (Hemorrhage)</b> DUE TO <b>Art. Hemiplegia</b> (b) <b>Penal Asphyxia</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>10/16/67</b> 2 days								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus, 35 yrs.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/18</b> , 19 <b>67</b> , to <b>2/18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/18</b> , 19 <b>67</b> , and that death occurred at <b>9:55</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>Prof. S. Gardner Jr.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/18/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Prof. S. GARDNER JR.</b>				22d. ADDRESS <b>MEDICAL CENTER, SALISBURY, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-21-1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>First Baptist</b>		23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City, Wor. Md.</b>			
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05830

UNITED STATES OF AMERICA

05830

Alameda

California

Benjamin General Hospital



02879

CERTIFICATE OF DEATH

02871

1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>1543 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. STREET ADDRESS <b>10 Locust Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Eileen</b> Last <b>HOWELL</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1928</b>
9. AGE (In years last birthday) yrs. <b>38</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 0 0 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Queen Anne Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. Baynard</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Coleman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-14-3456</b>	
17. INFORMANT <b>E.J. Baynard, Easton, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningioma (Left) Frontal Lobe with surgery.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>223X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs. 6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 14, 19 62</b> , to <b>February 4 19 67</b> , that (I) (we) last saw the deceased alive on <b>February 4 19 67</b> , and that death occurred at <b>3:33 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. Chalkey</b>		22b. DATE SIGNED <b>2-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L. V. Maldve</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/7/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Md.</b>	
24. FUNERAL DIRECTOR <b>MURICE E. NEUNAM &amp; SON, Easton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

02872

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>N. Division St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cia Frances Hudson</b> 4. DATE OF DEATH Month Day Year <b>February 8 1967</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>8/14/1891</b> 9. AGE (In years last birthday) <b>75 yrs.</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leonard F. Townsend</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b> 16. SOCIAL SECURITY NO. <b>229-18-2868</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Carter</b> 17. INFORMANT <b>Fred Hudson Dobbs Ferry, N.Y.</b> Address <b>10522</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Unk.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>66</b> , to <b>Feb 8</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>2/8</b> 19 <b>67</b> , and that death occurred at <b>7:55 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>George A. Henning</b> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT <b>Reinterment</b>		23b. DATE THEREOF <b>2/11/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>Charles C. Niet - Salisbury, Md.</b> ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 14 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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California

San Francisco General Hospital

Alameda

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>St Martin Ave</u>			
3. NAME OF DECEASED (Type or print) <u>NOAH J. HUDSON</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/1889</u>	9. AGE (In years last birthday) yrs. <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Police (Retired) Town Police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Burch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>221-20 8742A</u>		17. INFORMANT <u>Elia Hudson - Bishopville - Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14</u> , 19 <u>67</u> , to <u>Feb 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 20</u> , 19 <u>67</u> , and that death occurred at <u>5:10</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Ronald James Millstone, Del.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Georgetown - Del.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 24 1967</u>	
24. FUNERAL DIRECTOR <u>Ronald James Millstone, Del.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 5 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanjemoy</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>305 N. Clairmont Drive</b>				d. STREET ADDRESS <b>R.D.#1 90A</b>			
3. NAME OF DECEASED (Type or print) First <b>ARLIE</b> Middle <b>CARTER</b> Last <b>HUGHES</b>				4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 20, 1908</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>25</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boat Const. Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mahan, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Harvey Hughes</b>				14. MOTHER'S MAIDEN NAME <b>Phoebie Powers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>400-07-7403</b>			
17. INFORMANT <b>Mrs. Nellie Hughes (Wife)</b>				Address <b>R.D.#1 90A, Nanjemoy, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dermatomyositis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-3-67</b> to <b>3-15-67</b> that (I) (we) last saw the deceased alive on <b>2-5-67</b> and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Hubert R. White, Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 16 / 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Hubert R. White</b>				22d. ADDRESS <b>Fruitland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lewis Family Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Willards, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				ADDRESS <b>256 REGISTRAR'S SIGNATURE Charles Judge</b> DATE <b>FEB 20 1967</b>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02883

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02875

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>22-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>311 Locust Terrace</b>				d. STREET ADDRESS <b>311 Locust Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JABE</b> Middle <b>DEXTER</b> Last <b>HYLTON, JR.</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 67</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1920</b>		
9. AGE (In years lost birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>27</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jabe D. Hylton, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Ann E. Felicia Slusher</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-03-5101A</b>		17. INFORMANT <b>Mrs. Ann H. Disharoon (Mother)</b> <b>311 Locust Terrace, Salisbury, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> 443X DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Hypertensive C.V. Disease</b> (b) <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Maryland</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
22. DATE SIGNED <b>Feb. 22/1967</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

7880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

02886				MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
Items 11,12,13,14 Film G 386				CERTIFICATE OF DEATH		02876	
3/13/67 jml							
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>22-1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b> d. STREET ADDRESS <b>22-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Addie Jackson</b>				4. DATE OF DEATH Month Day Year <b>February 12 1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-05-22</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 Year Months Days		IF UNDER 24 Hrs. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hebron, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Will Hayward</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Custis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Metastatic Ca of Cx</b> (c) <b>Leukemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/24/67</b> , 19 <b>67</b> to <b>2/12/67</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>2/12/67</b> , 19 <b>67</b> , and that death occurred at <b>12:40</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Heiko Bauckemmann</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HEIKO BAUCKEMANN</b>				22d. ADDRESS <b>P.O. Box 15</b>			
23a. BURIAL CREMATION <b>BURIAL</b> (Specify)		23b. DATE THEREOF <b>2/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pikes Road</b>		23d. LOCATION (City or town) (County) (State) <b>Pikes Road Wic Md</b>	
24. FUNERAL DIRECTOR <b>Brother M. West, Salisbury</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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[illegible]

1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 25



FOR STATE  
HEALTH DEPT.

02885

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02877

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsborg, Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Peninsula General Hospital</u>				d. STREET ADDRESS <u>Box 165</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Deborah Nadine Jones</u>				4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-21-60</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Whaleyville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SEAMAN JONES</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Everett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Shirley Jones</u> Address <u>Parsonsborg Md. Box 165</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture dislocation of the cervical spine</u> 8124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by car as she ran across road.</u>					
20c. TIME OF INJURY Month, Day, Year <u>7:15 p.m. 2-3-67 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 346</u>		20f. (City or town) (County) (State) <u>Parsonsborg, Wicomico, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				22. DATE SIGNED <u>February 7, 1967</u>			
EXAMINER'S NAME (Type) <u>109 Camden Ave., Salisbury, Md.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEN HICKS MEM. PK.</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury Wico. Md.</u>	
24. FUNERAL DIRECTOR <u>Jolley Funeral Home, Salisbury, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0582X

0582X

*[Handwritten signature]*

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

02886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02878

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN lb <b>5 MO.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		d. STREET ADDRESS <b>407 CAMDEN AVE.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PENINSULA GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERALD</b> Middle <b>*****</b> Last <b>KING</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 26, 1923</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Willard King</b>		14. MOTHER'S MAIDEN NAME <b>Alice Lazette</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W War 2</b>		16. SOCIAL SECURITY NO. <b>262.24.9494</b>	
17. INFORMANT <b>Wife: Mrs. Glova King</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pyelonephritis of right kidney, severe</b> DUE TO (b) <b>Pseudomonas aeruginosa</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Bronchopneumonia, bilaterally, early</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>two weeks</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Stephan Tynkiw</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Stephan Tynkiw, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>J.T. STANSBERRY</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

15818

8838

1-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02887											
CERTIFICATE OF DEATH											
02879											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>R.D. #1</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>HELEN ELIZABETH LANDING</b>						4. DATE OF DEATH Month Day Year <b>February 9 19 67</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 25, 1891</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Washington Basford</b>						14. MOTHER'S MAIDEN NAME <b>Druicilla Frances Revelle</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-48-5799</b>		17. INFORMANT (Address) <b>Miss Frances Landing (Daughter) R.D.#1, Cedar Lane, Salisbury, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>degenerative heart disease - congestive heart failure</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 2/9, 1967</b> , that (I) (we) last saw the deceased alive on <b>2/8, 19, 67</b> , and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. E. M. Beardsley</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 10/1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. M. Beardsley</b>						22d. ADDRESS <b>207 Maryland Ave., Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 12, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>			
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 14 1967</b>					
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

05833

05833

General and Administrative  
Medical Services

Department of Health Services

Dr. J. H. [Signature]

Top. 11/1/67

11/1/67

11/1/67

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11/1/67



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02888

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02880

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Pocomoke City</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>River Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>J.</u> Last <u>LEWIS</u>			4. DATE OF DEATH Month <u>2-13-67</u> Day <u>19</u> Year <u>19</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-1875</u>		9. AGE (In years lost birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ships Master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Rev. Joseph Lewis</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Whealton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-12-3438</u>		17. INFORMANT <u>Mrs H. Victor Keen, Pocomoke City, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4231</u> IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Congestive heart failure</u> DUE TO (c) <u>Advanced ASCVD</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>  <u>Minutes</u>  <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous carcinoma of mouth</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Died during surgery for squamous carcinoma of mouth.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>February 14, 1967</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-1967</u>		23c. NAME OF CEMETERY <u>First Baptist</u>	
23d. LOCATION (City or Town) (County) (State) <u>Pocomoke City Wor. Md.</u>		23e. REC'D BY REGISTRAR DATE <u>FEB 17 1967</u>			
23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23g. REGISTRAR'S NAME <u>Charles Judge</u>			

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*[Handwritten signature]*

02889

## CERTIFICATE OF DEATH

02881

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b> d. STREET ADDRESS <b>R.F.D. 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) <b>LIDA ALICE MADDOX</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>FEBRUARY 20 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1892</b> 9. AGE (In years last birthday) <b>74</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Worcester County, Maryland</b>
13. FATHER'S NAME <b>Robert Watson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Powell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Helen Maddox, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Anteroselective Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day + 12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <b>Anteroselective Heart Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 8</b> , 19 <b>67</b> , to <b>Feb 20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb 20</b> , 19 <b>67</b> , and that death occurred at <b>9:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED	22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore, M.D.</b>
22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-23-1967</b>	23c. NAME OF CEMETERY <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City Wor. Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 24 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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INSTITUTE OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02890					02882				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE				
Wicomico MARYLAND					Maryland Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Salisbury					Salisbury				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
Peninsula General Hospital					606 Waverly Street				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last MAY REGINA MINOGUE					Month Day Year February 2 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 26, 1899		67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House-Wife & teacher (Retired) School						Baltimore, Maryland		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
James Quinlan					Mary Kennedy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
No									
17. INFORMANT					Address				
Mr. Edward A. Minogue (Husband)					606 Waverly Street, Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism &amp; Infarction</i> 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Phlebotrombosis</i> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<i>Generalized Arteriosclerosis &amp; Splenic Artery Thrombosis</i>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
					N/A				
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from 1-31-1967, to 2-3-1967 that (I) (we) last saw the deceased alive on 2-1-1967, and that death occurred at 8:25M, from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		
<i>James L. Clifford</i>					M.D.		Feb. 3 / 1967		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Dr. James L. Clifford					Medical Center, Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			Feb. 6, 1967		Druid Ridge Cemetery		Baltimore County, Maryland		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
HOLLOWAY & COMPANY, SALISBURY, MARYLAND					FEB 6 1967				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be removed and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 (M)

02891

CERTIFICATE OF DEATH

02883

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>203 Bay Street</u>			
3. NAME OF DECEASED (Type or print) <u>Audrey Mae Mumford</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31, 1907</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FRANKFORD, DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CARRIE ROGERS</u>				14. MOTHER'S MAIDEN NAME <u>MAE HUDSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-12-6171</u>		17. INFORMANT <u>GEORGE W. MUMFORD</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> 5271 DUE TO <u>with chronic COPD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>67</u> , to <u>2/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/26</u> , 19 <u>67</u> , and that death occurred at <u>8:41</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City or Town) (County) (State) <u>BERLIN WOR MD</u>	
24. FUNERAL DIRECTOR <u>Anne A. Dumbage Berlin Md</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

05863

03881

Is this correct?

Feb 28 1951

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

02892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02884

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>516 E. Locust Street</b>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>ANNETTE</b> Last <b>MYERS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1914</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>24</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Jacksonville, Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph Carter</b>		14. MOTHER'S MAIDEN NAME <b>(Unk.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>541-34-5906</b>	
17. INFORMANT <b>Mr. John E. Myers (Husband)</b>		Address <b>516 E. Locust Street, Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auto Pulmonary Edema</b> <b>8/20</b> DUE TO <b>multiple fractures</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by truck crossing Hwy -</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:30 a.m. 1-11-67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 13</b>
20f. (City or town) <b>Salisbury</b>		(County) <b>Wicomico</b> (State) <b>MD.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>409 Camden Avenue, Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>February 6 / 1967</b>		Address (Street, city, town, or county) <b></b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 8, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellow Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Laurel, Delaware</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

05884

03022

AMERICAN AIRWAYS

*Went to ...*  
*Went to ...*

*Went to ...*  
*Went to ...*

*Went to ...*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02885

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Peninsula General Hospital</b>		d. STREET ADDRESS <b>348 Cedar Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>LUCILLE</b> Middle <b>E.</b> Last <b>NICHOLAS</b>		4. DATE OF DEATH Month <b>2-19-67</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1912</b> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>	
13. FATHER'S NAME <b>Perry Dutton</b>		14. MOTHER'S MAIDEN NAME <b>Mary W. Nichols</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT <b>Esther Gale - Fruitland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Acute congestive heart failure</b> DUE TO (c) <b>1341</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>		22. DATE SIGNED <b>February 23, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-25-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Md. Wic</b>
24. FUNERAL DIRECTOR <b>Jolley Funeral Home, Salisbury, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

05882

05882

Handwritten notes and stamps, including a date stamp "2-10-1912" and a signature "J. H. [illegible]".

Handwritten notes and stamps, including a date stamp "2-10-1912" and a signature "J. H. [illegible]".



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02894

## CERTIFICATE OF DEATH

02886

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> <b>22-1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>3 Wks.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MAMIE HOLLOWAY PARKER</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11, 1893</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months <b>28</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland, Wicomico</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elisha Holloway</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-7952</b>	
17. INFORMANT <b>Mrs. Thomas Mumford, Sec. 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> DUE TO (b) <b>Phlebotrombosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Idiopathic Thrombocytopenic Purpura</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 8, 1967</b> , to <b>Feb 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb 28, 1967</b> , and that death occurred at <b>12:38</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill Jr.</b>		22b. DATE SIGNED <b>3/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas C. Hill Jr.</b>		22d. ADDRESS <b>Pine Bluff Road, Salisbury, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-2-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>Hill Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05888

CONFIDENTIAL - DECLASSIFIED

05888

MAR 6 1981

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02895

CERTIFICATE OF DEATH

02887

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>		19-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Taylor Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Velma Hercelia Payne</b>		4. DATE OF DEATH Month Day Year <b>February 1 19 67</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1907</b>		9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Minos Cohee</b>				14. MOTHER'S MAIDEN NAME <b>Katie Robinson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-8649</b>		17. INFORMANT Address <b>Mrs. Charlotte Hearne, Secretary, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4331</b> IMMEDIATE CAUSE (a) <b>atrial fibrillation</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31, 1967</b> to <b>Feb 1, 1967</b> that (I) (we) lost saw the deceased alive on <b>Feb 1, 1967</b> and that death occurred at <b>8:17</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Youngs Moon</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 1, 1967</b>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Williamsburg, Maryland</b>	
24. FUNERAL DIRECTOR'S ADDRESS <b>J. B. Frampton and Son, Federalsburg, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02882

CHIEF OF STATE

02882

Wisconsin

Salmon

Peninsula General Hospital

Nov 11

Nov 11, 1907

Salmon, Oct 11, 1907

Salmon, Oct 11, 1907

Salmon, Oct 11, 1907

Salmon, Oct 11, 1907

Salmon, Oct 11, 1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02896

CERTIFICATE OF DEATH

02888

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PITTSVILLE</b> d. STREET ADDRESS <b>RT.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lelia Jackson Pennewell</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 4 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 2, 1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMECHEIF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>PARSONSBURG MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>GEORGE EDWARD JACKSON</b>		14. MOTHER'S MAIDEN NAME <b>SARAH RICHARDSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-20-4059</b>	
17. INFORMANT <b>Mrs RUTH JONES</b>		Address <b>PITTSVILLE MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-3</b> , 19 <b>67</b> to <b>2-4</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>2-4</b> , 19 <b>67</b> , and that death occurred at <b>10</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>2-4-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BURIAL</b>	23d. LOCATION (City or Town) (County) (State) <b>PITTSVILLE WIC MD</b>
24. FUNERAL DIRECTOR <b>Anne A. Burbage</b>		25a. REC'D BY REGISTRAR <b>[Signature]</b>	
ADDRESS <b>Burien Md</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
DATE <b>FEB 8 1967</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

02897

CERTIFICATE OF DEATH

02889

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>Salisbury</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>700 E. Church Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CRESTON ARRILUS (RILL) POLLITT</b>		4. DATE OF DEATH Month Day Year <b>February 3 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1877</b>
9. AGE (In years last birthday) <b>89 yrs.</b>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>2 28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua D. Pollitt</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Ellen Maddox</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-26-4408 A</b>	
17. INFORMANT <b>Mrs. Irma Kieffer &amp;/or Mrs. Naomi Long,</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic coronary artery disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>not known</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/26/67</b> to <b>2/3/67</b> that (I) (we) last saw the deceased alive on <b>2/3/67</b> and that death occurred at <b>7:45 p.m.</b> from causes and on the date stated above.		22a. SIGNATURE <b>Dr. O. J. Burton</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>Feb. 3 /1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. O. J. Burton</b>		22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 6, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 6 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Wisconsin

Bellevue

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

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Bellevue General Hospital

Bellevue General Hospital

Bellevue General Hospital

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## CERTIFICATE OF DEATH

02890

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>1 Day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Meadow Bridge Rd.,</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First Middle Last		4. DATE OF DEATH <b>February 7, 1967</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	9. AGE (In years last birthday) <b>94</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? A. <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Raymond</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. John Raymond Grace St. Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>334X</b> IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO (b) <b>Viral Encephalitis</b> DUE TO (c) <b>Dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>Second day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17, 1966</b> to <b>Feb. 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 7, 1967</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>G. Herbert Sembley</b> M.D.		22b. DATE SIGNED <b>2/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Herbert Sembley</b>		22d. ADDRESS <b>Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-9-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Eden, Wicomico, Maryland</b>
24. FUNERAL DIRECTOR <b>Hill Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
02899						02891																	
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)																	
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY														
Wicomico			Salisbury			Maryland			Wicomico														
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS														
3 days			Wicomico Nursing Home			Willards, RFD.			Booth Street														
e. IS RESIDENCE ON A FARM?			3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?														
YES <input type="checkbox"/> NO <input type="checkbox"/>			First Middle Last			Month Day Year			YES <input type="checkbox"/> NO <input type="checkbox"/>														
			Rayne Little Cullen			February 3 1967																	
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH														
F			W			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8/25/88														
9. AGE (In years last birthday)			10. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?														
78 yrs.			Housewife			Own Home			Maryland														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?														
Housewife			Own Home			Maryland			USA														
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME																	
Jackson Lee Dennis						Annie Jane Powell																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.						17. INFORMANT											
X						212-10-9101						Alvin Dennis											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						19. INTERVAL BETWEEN ONSET AND DEATH																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Cerebral Thrombosis						6 weeks											
332X						DUE TO																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Cerebral Arteriosclerosis																	
						(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year												20d. INJURY OCCURRED											
Hour a.m. p.m. 19												While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1967, to Feb. 3, 1967, that (I) (we) last saw the deceased alive on Feb. 3, 1967, and that death occurred at 20 M, from the causes and on the date stated above.												22a. SIGNATURE											
												22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)												22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE THEREOF											
Burial												2/6/67											
23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City, town or county) (State)											
Mt. Pleasant												Willards, Md.											
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR											
Peter Whaley Salisbury, Del.												25b. REGISTRAR'S SIGNATURE											
												FEB 8 1967											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02900

## CERTIFICATE OF DEATH

02892

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>301 Maryland Ave.,</u>		d. STREET ADDRESS <u>301 Maryland Ave.,</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mollie Driscoll Rayne</u>		4. DATE OF DEATH Month Day Year <u>2 27 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) yrs. <u>69</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Driscoll</u>		14. MOTHER'S MAIDEN NAME <u>Ada Gertrude Evans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-32-1232</u>	
17. INFORMANT <u>S.W. Rayne, Jr</u>		Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cystitis - acute</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> , 19 <u>67</u> , to <u>2-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-23</u> , 19 <u>67</u> , and that death occurred at <u>11 A.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas P. Bigbee</u>		22b. DATE SIGNED <u>2-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Bigbee</u> M.D.		22d. ADDRESS <u>211 Maryland Ave., Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/2/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR <u>Hill Funeral Home</u> <u>Salisbury, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 1 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 From G386 3/7/67 mh

02901

CERTIFICATE OF DEATH

02893

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salis</b> d. STREET ADDRESS <b>Salis</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Minnie C Rhodes</b>		4. DATE OF DEATH Month Day Year <b>February 23 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 21-1884</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Accomack Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter W. Ponniwell</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Lewis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Amanta Lewis</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Anterior Myocardial Infarction, Extensive</b> (b) <b>Thrombotic Coronary Artery Disease</b> DUE TO <b>Occlusion Descending Coronary Artery, Left</b> (c) <b>Arteriosclerosis Heart &amp; Kidney</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cepto, Renal</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20e. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/5</b> , 19 <b>67</b> , to <b>2/23</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/23</b> , 19 <b>67</b> , and that death occurred at <b>4:20</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Rufus S Gardner Jr</b>		22b. DATE SIGNED <b>2/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RUFUS SGARDNER JR</b>		22d. ADDRESS <b>MEDICAL CENTER, SALISBURY</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-26-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Drewes</b>		23d. LOCATION (City or Town) (County) (State) <b>Salis - Accomack Co</b>	
24. FUNERAL DIRECTOR <b>James H. Fox</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 2 1967</b>	
ADDRESS <b>Temperanceville, Va</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

80880

UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02902

CERTIFICATE OF DEATH

02894

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>1 day.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KATIE RICKARDS</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9. AGE (In years last birthday) yrs. <b>91</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Smith</b>		14. MOTHER'S MAIDEN NAME <b>Northa Murray</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>X X X</b>		16. SOCIAL SECURITY NO. <b>214-36-5083</b>	
17. INFORMANT <b>Raymond Hudson</b>		Address <b>Bishopville Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201 Myocardial Infarction</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Hypertensive Coronary Artery disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>2/22/67</b> , 19 <b>67</b> , to <b>2/23/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/23/1967</b> , and that death occurred at <b>2:15</b> P.M. from causes and on the date stated above.	
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>L.O.C.F.</b>
23d. LOCATION (City or Town) (County) (State) <b>Bishopville Md.</b>		24. FUNERAL DIRECTOR <b>Killer Whaley Salisbury, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>FEB 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



02880

STATE OF TEXAS

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Doc No

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Johnson, James A.

Doc No

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Doc No

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Doc No

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Doc No

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Doc No

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Doc No

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Doc No

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02903

## CERTIFICATE OF DEATH

02895

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>PRINCESS ANNE</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b> d. STREET ADDRESS <b>19-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John D. RIDGWAY</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>FEBRUARY 18 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/24/1899</b> 9. AGE (In years last birthday) yrs. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BUILDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WESTCHESTER, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. RIDGWAY</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE PASSMORE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WAR 1</b>		16. SOCIAL SECURITY NO. <b>165-28-9810A</b>	
17. INFORMANT <b>MRS LILLIAN RIDGWAY PRINCESS ANNE, MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>4200</b> DUE TO (b) <b>Arterio-sclerotic Heart disease</b> DUE TO (c) <b>cardiac</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-10, 1967</b> to <b>2-18, 1967</b> , that (I) (we) last saw the deceased alive on <b>2-18, 1967</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Levellan R. Elbert</b>		22b. DATE SIGNED <b>2-18-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/22/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HIGHLAND MEMORIAL PARK POTTSTOWN, PA.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>LEVIN R. WILSON PRINCESS ANNE, MD.</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02883

02881

Wisconsin

Salisbury

Peninsula General Hospital

7/24/1983

67

U.S.A.

WESTCHESTER, PA.

PRINCESS ANGEL

JOHN W. BILWAY

10-18-83

2/22/1987

WIGHTMAN MEMORIAL PARK

PA.

PRINCESS ANGEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02904

CERTIFICATE OF DEATH

02896

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ATLANTIC</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Box #139</u>			
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>MAE</u> Last <u>ROGERS</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Nov. 22, 1906</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u> Hours <u>—</u> Min. <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Gerald Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Betty Trout</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Gerald Rogers, Box #139, Atlantic, VA.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>5710</u> IMMEDIATE CAUSE (a) <u>Pericardial Constrictive Collapsus</u> DUE TO (b) <u>Dehydration and Acidosis</u> DUE TO (c) <u>Hypertension, viral, acute</u> 3 day							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/23/1967</u> , to <u>2/24/1967</u> , that (II) (we) last saw the deceased alive on <u>2/24/1967</u> , and that death occurred at <u>1:12</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred C. Koles</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Alfred C. Koles</u>				22d. ADDRESS <u>Medical Center, Salisbury, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/24/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHRISTIAN</u>		23d. LOCATION (City or Town) (County) (State) <u>Snow Hill, MD</u>	
24. FUNERAL DIRECTOR <u>Edward Bonds</u>				ADDRESS <u>Snow Hill, MD</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05886

CONTINUITY OF DATA

05886

Location

Ball's Bluff

Stationary and/or Mobile

100-100000-100000

100-100000-100000

100-100000-100000

02905

## CERTIFICATE OF DEATH

02897

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY in 1b <b>Adm. in 1b 2/8/67</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>511 Regency Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAYMOND SAMUEL SMACK, Sr.</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 21 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1913</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>8 20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads Comm.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Smack</b>		14. MOTHER'S MAIDEN NAME <b>Susan Butler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War II</b>		16. SOCIAL SECURITY NO. <b>220-36-8229</b>	
17. INFORMANT <b>Mrs. Norma Lee Smack (Wife)</b> <b>511 Regency Drive, Salisbury, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC Heart Disease</b> DUE TO (c) <b>HYPERTENSION and Diabetes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 8, 1967</b> to <b>Feb 21, 1967</b> that (I) (we) last saw the deceased alive on <b>Feb 20, 1967</b> , and that death occurred at <b>7:55 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill Jr.</b>		22b. DATE SIGNED <b>Feb 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill, Jr.</b>		22d. ADDRESS <b>PINE BLUFF Rd., SALISBURY MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 23, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Accomac Co., Virginia</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 23 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



058807

03807

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		January 1, 1945	
Age		35 years	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Cause of Death		Heart Disease	
Place of Death		New York City	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		January 5, 1945	
City		New York	
County		New York	
State		New York	



02906

## CERTIFICATE OF DEATH

02898

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>23-2</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>		d. STREET ADDRESS <b>Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>MARY</b>		Middle <b>V</b>		Last <b>SMITH</b>		4. DATE OF DEATH <b>Feb. 27</b>		Month <b>19</b>		Day <b>67</b>		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 13, 1886</b>		9. AGE (In years lost birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months <b>23</b>		Days <b>2</b>		IF UNDER 24 HRS. Hours <b>23</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Elijah Perdue</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Sturgis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-6779</b>	
17. INFORMANT <b>Mrs. Virginia M. Seipp</b>		Address <b>3235 Faiesta</b>		City <b>La Crescenta</b>		State <b>Calif</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>2/24</b> , 19 <b>67</b> to <b>2/27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/26</b> , 19 <b>67</b> , and that death occurred at <b>5:14</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Earl M. Beardsley</b>		22b. DATE SIGNED <b>2/27/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Earl M. Beardsley</b>		22d. ADDRESS <b>Salisbury, Md.</b>		22e. REC'D BY REGISTRAR <b>Charles Judge</b>		22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		22g. DATE <b>MAR 2 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/1/1967</b>		23c. NAME OF CEMETERY <b>All Hallows Episcopal</b>		23d. LOCATION (City or Town) (County) (State) <b>Snow Hill, Md.</b>		23e. REC'D BY REGISTRAR <b>Charles Judge</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		23g. DATE <b>MAR 2 1967</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (You please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

02880

RECEIVED ON DEATH

02880

Form with multiple sections and fields, including a large central area with a circular stamp and various administrative markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02907

CERTIFICATE OF DEATH

02899

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>15 Calhoun Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>TODD</b> Middle <b>STEWART</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> Baby <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4:30PM</b> <b>Feb. 13, 1967</b>		9. AGE (In years last birthday) <b>0</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Preston Randle Smith</b>				14. MOTHER'S MAIDEN NAME <b>Polly Mae Stewart</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mr. Preston R. Smith (Father)</b> <b>15 Calhoun Ave., Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perinatal asphyxia, aspiration of fluid</b> 7610 DUE TO (b) <b>Prolapsed cord</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Premature separation of membranes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hr 45</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2/13</b> App. 19 <b>67</b> , to <b>2/14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/14</b> 19 <b>67</b> , and that death occurred at <b>12:10</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>D. S. Anderson</b>				22b. DATE SIGNED <b>Feb. 16/1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. D. G. Anderson</b>				22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>Feb 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>J. H. ...</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02908

## CERTIFICATE OF DEATH

02900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Salisbury</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>408 Winder Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>408 Winder Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LESTER</b>		First <b>MARTIN</b>		Middle <b>STEELE</b>		Last <b>STEELE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1902</b>		9. AGE (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>7</b> Hours <b></b> Min. <b></b> IF UNDER 24 HRS. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dispatcher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Power &amp; Light Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lewes, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elmer Steele</b>					14. MOTHER'S MAIDEN NAME <b>Eunice Spicer</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mrs. Bernice W. Steele (Wife)</b> <b>408 Winder Street, Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>N/A</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Salisbury, Maryland</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>1947</b> , 19 <b>1947</b> , to <b>2-2-67</b> , 19 <b>1967</b> , that (I) (we) last saw the deceased alive on <b>2-31-67</b> , 19 <b>1967</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Lee L. Lawry</b>						22b. DATE SIGNED <b>Feb. 3 / 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee L. Lawry</b>						22d. ADDRESS <b>315 N. Division St., Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>FEB 6 1967</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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## CERTIFICATE OF DEATH

02903

02901

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DELAWARE</b>		b. COUNTY <b>SUSSEX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLSBORO</b>		d. STREET ADDRESS <b>116-2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>												4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-19-1886</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				11. BIRTHPLACE (County & State, or foreign country) <b>DELAWARE</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>CLAYTON ATKINS</b>						14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH ATKINS</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>222-01-7286</b>				17. INFORMANT <b>MRS. DALLAS HUDSON, MILLSBORO</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable pulmonary infarction</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Deep vein thrombosis of left lower extremity</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease - degenerative</b>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Suspect neoplasm of lung</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1-12-1967</b> , to <b>2-1-1967</b> , that (I) (we) last saw the deceased alive on <b>1-31-1967</b> , and that death occurred at <b>7:20</b> M, from causes and on the date stated above.															
22a. SIGNATURE <b>James L. Clifford</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>2-1-67</b>							
22c. PHYSICIAN'S NAME (Type) <b>JAMES L. CLIFFORD</b>				22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2-5-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MILLSBORO CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>MILLSBORO, DEL.</b>					
24. FUNERAL DIRECTOR <b>A. Douglas Melton</b>				ADDRESS <b>Frankford, Del.</b>				25a. REC'D BY REGISTRAR <b>FEB 14 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03201

CERTIFICATE OF DEATH

03201

Hiscocks

California

San Francisco General Hospital

02910

## CERTIFICATE OF DEATH

02902

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>432 Druid Hill Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR F. STRAN</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>9</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-19-1892</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b>		11. IF UNDER 24 HRS. Hours <b>14</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocery Business</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry P. Stran</b>				14. MOTHER'S MAIDEN NAME <b>Alverda Rictor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-07-4289</b>		17. INFORMANT Address <b>Louise Stran-432 Druid Hill Ave. Salisbury</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-23, 1967</b> to <b>2-9, 1967</b> , that (I) (we) last saw the deceased alive on <b>2-9, 1967</b> , and that death occurred at <b>7 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>William R. [Signature]</b>				22b. DATE SIGNED <b>2-9-67</b>		22c. PHYSICIAN'S NAME (Type) <b>William R. [Signature]</b>	
22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-13-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Ellsworth [Signature]</b>				ADDRESS <b>4600 Liberty Hghts. Avenue</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02911

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02903

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>			d. STREET ADDRESS <b>R.D. #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>SAMUEL</b> Last <b>TINDLE</b>			4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1895</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b> Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Wicomico County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Robert R. Tindle</b>			14. MOTHER'S MAIDEN NAME <b>Martha Driscoll</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	17. INFORMANT <b>Mrs. Helen C. Tindle (Wife)</b> <b>R.D. #1, Pittsville, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fx Dorsal Spine &amp; several ribs</b> 8239 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of vehicle ran off road</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 353</b>		20f. City or town (County) (State) <b>Pittsville Wicomico Md</b>
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D.		22. DATE SIGNED <b>February 3, 1967</b>	
EXAMINER'S NAME (Type) <b>409 Camden Avenue, Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 6, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Farlow Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pittsville, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALIBURY, MARYLAND</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Adm. in 1 D</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>711 Taylor Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE WASHINGTON TOWNSEND</b>						4. DATE OF DEATH Month Day Year <b>February 19 19 67</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 10, 1879</b>		9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>6 9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Huckster</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Worcester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Townsend</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Butler</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-10-2126</b>		17. INFORMANT Address <b>Mrs. Martha P. Townsend (Wife)</b> <b>711 Taylor Street, Salisbury, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>4500</b> DUE TO <b>Massive infarct of L. Lung</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) <b>Embolus L. Arm</b> DUE TO <b>Arteriosclerosis (widespread)</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Salisbury, Wicomico</b>					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Salisbury</b>		20g. (County) <b>Wicomico</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/18/67</b> to <b>2/19/67</b> , that (I) (we) last saw the deceased alive on <b>2/18/67</b> , and that death occurred at <b>2:55 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Carrie I. Hearn</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 20/1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearn</b>						22d. ADDRESS <b>226 N. Division Street, Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles J. J.</b>			

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## CERTIFICATE OF DEATH

02905

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hoopersville</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>09-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George W TRAVERS</u>		4. DATE OF DEATH Month Day Year <u>February 27 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1904</u>
9. AGE (In years lost birthday) <u>62 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilbert Travers</u>		14. MOTHER'S MAIDEN NAME <u>Delia Travers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-6254</u>	
17. INFORMANT <u>Flora L. Travers, Hoopersville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Prostate</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>1 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>--</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>February 21, 1967</u> , to <u>February 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>February 27, 1967</u> , and that death occurred at <u>1:55 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. H. Winnacott</u>		22b. DATE SIGNED <u>2-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. H. Winnacott</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/5/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Maryland</u>
24. FUNERAL DIRECTOR <u>Herbert H. Clark Jr.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02914

## CERTIFICATE OF DEATH

02906

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Adm in 1D 1714/67</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b> d. STREET ADDRESS <b>In Village</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Manie POLONIA</b>		4. DATE OF DEATH Month Day Year <b>February 25 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1877</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Employee</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Powellville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lambert Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Zenia Bradford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-52-8054</b>	
17. INFORMANT <b>Mrs. Mary Cathell (Daughter)</b> <b>Box 101, Berlin, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>332X Cerebral Thrombosis</b> IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 14, 1967</b> to <b>Feb 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb 25, 1967</b> , and that death occurred at <b>2 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>Feb. 25/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 1, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Willards Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Willards, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03030

03014

FEB 28 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02915

Items 8 & 9 Film G386 3/17/67 KK  
CERTIFICATE OF DEATH

02907

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Ocean City 13-2</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>			d. STREET ADDRESS <b>Rt 41 Box 373</b>		
3. NAME OF DECEASED (Type or print) <b>EMANUEL FRANCIS TYLER</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>23</b> Year <b>1967</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1918</b>		9. AGE (In years last birthday) <b>48 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Orangeburg S.C.</b>	
13. FATHER'S NAME <b>Prince Tyler</b>		14. MOTHER'S MAIDEN NAME <b>Geneva Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>251-28-088</b>		17. INFORMANT <b>Estella Tyler - Rt 41 Box 373</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>deft Ventricular Failure</b> (c) <b>Hypertensive Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>Edays</b> <b>Not known</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gross Obesity (5ft 6" 320 lbs.)</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/23/1967</b> to <b>2/23/1967</b> that (I) (we) last saw the deceased alive on <b>2/23/1967</b> and that death occurred at <b>7:30</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>[Signature]</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-6-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY LAKE</b>		23d. LOCATION (City or Town) (County) (State) <b>Orangeburg S.C.</b>	
24. FUNERAL DIRECTOR <b>[Signature]</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 3 1967</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>		

2180

1234567891011121314151617181920212223242526272829303132333435363738394041424344454647484950515253545556575859606162636465666768697071727374757677787980818283848586878889909192939495969798991001011021031041051061071081091101111121131141151161171181191201211221231241251261271281291301311321331341351361371381391401411421431441451461471481491501511521531541551561571581591601611621631641651661671681691701711721731741751761771781791801811821831841851861871881891901911921931941951961971981992002012022032042052062072082092102112122132142152162172182192202212222232242252262272282292302312322332342352362372382392402412422432442452462472482492502512522532542552562572582592602612622632642652662672682692702712722732742752762772782792802812822832842852862872882892902912922932942952962972982993003013023033043053063073083093103113123133143153163173183193203213223233243253263273283293303313323333343353363373383393403413423433443453463473483493503513523533543553563573583593603613623633643653663673683693703713723733743753763773783793803813823833843853863873883893903913923933943953963973983994004014024034044054064074084094104114124134144154164174184194204214224234244254264274284294304314324334344354364374384394404414424434444454464474484494504514524534544554564574584594604614624634644654664674684694704714724734744754764774784794804814824834844854864874884894904914924934944954964974984995005015025035045055065075085095105115125135145155165175185195205215225235245255265275285295305315325335345355365375385395405415425435445455465475485495505515525535545555565575585595605615625635645655665675685695705715725735745755765775785795805815825835845855865875885895905915925935945955965975985996006016026036046056066076086096106116126136146156166176186196206216226236246256266276286296306316326336346356366376386396406416426436446456466476486496506516526536546556566576586596606616626636646656666676686696706716726736746756766776786796806816826836846856866876886896906916926936946956966976986997007017027037047057067077087097107117127137147157167177187197207217227237247257267277287297307317327337347357367377387397407417427437447457467477487497507517527537547557567577587597607617627637647657667677687697707717727737747757767777787797807817827837847857867877887897907917927937947957967977987998008018028038048058068078088098108118128138148158168178188198208218228238248258268278288298308318328338348358368378388398408418428438448458468478488498508518528538548558568578588598608618628638648658668678688698708718728738748758768778788798808818828838848858868878888898908918928938948958968978988999009019029039049059069079089099109119129139149159169179189199209219229239249259269279289299309319329339349359369379389399409419429439449459469479489499509519529539549559569579589599609619629639649659669679689699709719729739749759769779789799809819829839849859869879889899909919929939949959969979989991000100110021003100410051006100710081009101010111012101310141015101610171018101910201021102210231024102510261027102810291030103110321033103410351036103710381039104010411042104310441045104610471048104910501051105210531054105510561057105810591060106110621063106410651066106710681069107010711072107310741075107610771078107910801081108210831084108510861087108810891090109110921093109410951096109710981099110011011102110311041105110611071108110911101111111211131114111511161117111811191120112111221123112411251126112711281129113011311132113311341135113611371138113911401141114211431144114511461147114811491150115111521153115411551156115711581159116011611162116311641165116611671168116911701171117211731174117511761177117811791180118111821183118411851186118711881189119011911192119311941195119611971198119912001201120212031204120512061207120812091210121112121213121412151216121712181219122012211222122312241225122612271228122912301231123212331234123512361237123812391240124112421243124412451246124712481249125012511252125312541255125612571258125912601261126212631264126512661267126812691270127112721273127412751276127712781279128012811282128312841285128612871288128912901291129212931294129512961297129812991300130

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2/10/2001

7-10-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02916						02908					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>				d. STREET ADDRESS <u>R.F.D.#1 Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D.#1 Salisbury</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Levin C. Waters</u>						4. DATE OF DEATH <u>February 21 1967</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Waters</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Church</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>221-10-6008</u>					
17. INFORMANT <u>Elva Waters R.F.D.1 Salisbury Md.</u>						18. INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Indefinite</u>					
19. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alleged</u> <u>Prostatic Carcinoma</u> 177X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <u>Prostatic Carcinoma</u> DUE TO <u>Prostatic Carcinoma</u> DUE TO <u>Prostatic Carcinoma</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>21 Jan 1967</u> to <u>21 Feb 1967</u> that (I) (we) last saw the deceased alive on <u>21 Feb 1967</u> and that death occurred at <u>5:15 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>E. A. PARNELL</u>						22b. DATE SIGNED <u>28 Feb 67</u>					
22c. PHYSICIAN'S NAME (Type) <u>E. A. PARNELL</u>						22d. ADDRESS <u>652 W. MAIN St. Salisbury Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		23d. LOCATION (City, town or county) <u>Fruitland</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart Salisbury Md.</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

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## CERTIFICATE OF DEATH

02909

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>304 Oak Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET (NMI) WEIMER (WYMER)</b>		4. DATE OF DEATH Month Day Year <b>February 13 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1900</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11 8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(Unk.) Weimer</b>		14. MOTHER'S MAIDEN NAME <b>(Unk.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>282-03-9050</b>	
17. INFORMANT <b>Sarah V. Methvin (Daughter)</b>		Address <b>304 Oak Street, Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY DEPRESSION + ARREST</b> DUE TO (b) <b>CARCINOMA OF BREAST</b> DUE TO (c) <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>20 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/12/67</b> , 19 <b>67</b> , to <b>2/13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>67</b> and that death occurred at <b>2:42</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>B.C. Sanders</b>		22b. DATE SIGNED <b>2/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B.C. SANDERS</b>		22d. ADDRESS <b>Peninsula General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Feb. 20 / 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lee's Son's Co.</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02000

ESTIMATE OF WORK

02017

02010

02011

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

Peninsula General Hospital

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02918

## CERTIFICATE OF DEATH

02910

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Delmar (Rural)</b> 22.1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D. #3</b>			d. STREET ADDRESS <b>R.D.#3, RumRidge Road</b>		
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>AMELIA</b> Last <b>WELLS</b>			4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1880</b>		9. AGE (in years last birthday) <b>86</b> yrs. <b>5</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pittsville, Maryland</b>	
13. FATHER'S NAME <b>Benjamin Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Martha West</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Nicie E. Rennie (Daughter)</b> <b>R.D.#3, RumRidge Rd., Delmar, Md. (Del. 19940)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> 4201 DUE TO (b) <b>arteriosclerotic Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>10 YRS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1/28, 1960</b> to <b>2/1, 1967</b> that (I) (we) last saw the deceased alive on <b>2/1, 1967</b> and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph A. Elliott</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 7/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph A. Elliott</b>		22d. ADDRESS <b>714 West St., Laurel, Delaware</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Farlow Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Pittsville, Maryland</b>		24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>			
25a. REC'D BY REGISTRAR <b>DATE FEB 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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350183 - *Journal of the American Statistical Association*, 1987, 82, 1, 1-10, 12 refs.

02919

## CERTIFICATE OF DEATH

02911

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>1207 Dorchester St.</b>	
3. NAME OF DECEASED (Type or print) First <b>ELIJAH</b> Middle <b>---</b> Last <b>Whitehead</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1907</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Northampton County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Whitehead</b>		14. MOTHER'S MAIDEN NAME <b>Maude Richardson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-14-6094</b>	
17. INFORMANT <b>Mrs Christine Whitehead,</b>		Address <b>Pocomoke Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of myocardium</b> DUE TO (b) <b>Coronary Artery Thrombosis</b> DUE TO (c) <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>67</b> , to <b>2/28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/28</b> , 19 <b>67</b> , and that death occurred at <b>9P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-3-1967</b>	23c. NAME OF CEMETERY OR CREMATOR <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City Wor. Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>Robert H. Watson</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert H. Watson</b>		25c. DATE <b>MAR 6 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11080

01030

Form with multiple sections and fields, including a large table area. The text is mostly illegible due to blurriness and bleed-through from the reverse side. Visible text includes "11080" in the top left, "01030" in the top right, and various faint labels and numbers throughout the form structure.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02920

CERTIFICATE OF DEATH

02912

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pine Bluff State Hospital</b>		d. STREET ADDRESS <b>-</b>	
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Mae</b> Last <b>Wilkins</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elijah Tubbs</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Truitt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-56-0351</b>	
17. INFORMANT <b>Records of Pine Bluff State Hospital, Salisbury, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardio vascular disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Sept. 28, 1966</b> , to <b>Feb. 9, 1967</b> that <del>it</del> (we) last saw the deceased alive on <b>Feb. 9, 1967</b> , and that death occurred at <b>8:25</b> <b>pm</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>E. P. Ritchings</b>		22b. DATE SIGNED <b>Feb. 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>		22d. ADDRESS <b>Pine Bluff State Hospital Salisbury, Maryland 21801</b>	
23a. BURIAL, CREMATION, or other disposition <b>Buried</b>		23b. DATE THEREOF <b>2/12/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Hope</b>		23d. LOCATION (City or Town) (County) (State) <b>Willards Md.</b>	
24. FUNERAL DIRECTOR <b>Peter Whaley</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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MINISTRY OF DEFENSE

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1. General

2. Description

3. Remarks

4. Location

5. Date

6. Time

7. Name of vessel

8. Type

9. Number of crew

10. Number of passengers

11. Remarks

12. Remarks

13. Remarks

14. Remarks

15. Remarks

16. Remarks

17. Remarks

18. Remarks

19. Remarks

20. Remarks

21. Remarks

22. Remarks

23. Remarks

24. Remarks

25. Remarks

26. Remarks

27. Remarks

28. Remarks



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02921

## CERTIFICATE OF DEATH

02913

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Delmar Road</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EVELYN</b> Last <b>WILLIAMS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1926</b>		9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>27</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George T. Williams</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Ennis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>Mrs. Mamie Williams (Mother)</b> <b>Fruitland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 7543 DUE TO (b) <b>Pulmonary Artery Thrombosis</b> 465X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Interatrial Septal Defect</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asthma, Cyanosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs old. Congenital</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/25</b> <sup>App</sup> <b>1967</b> to <b>2/27</b> <b>1967</b> , that (I) (we) last saw the deceased alive on <b>2/27</b> <b>1967</b> , and that death occurred at <b>3</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Rufus S. Gardner, Jr.</b>				22b. DATE SIGNED <b>Feb. 28, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner</b>	
22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>				22e. REC'D BY REGISTRAR <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 2, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smullen Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Worcester Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

02922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02914

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deers Head State Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT W. WINDSOR, SR.</b>				4. DATE OF DEATH Month Day Year <b>2-20-67</b> 19			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 21, 1901</b>	
9. AGE (In years lost birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Wingate, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Hudson Windsor</b>				14. MOTHER'S MAIDEN NAME <b>Anna Frances Adams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-5215</b>		17. INFORMANT Address <b>Mrs. Tressie E. Windsor, Same as 2. abcd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Paraplegia, secondary to spinal cord lesion, lower thoracic</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Boating accident</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>PM 8-24 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tangier Sound</b>		20f. (City or town) (County) (State) <b>Crisfield Somerset Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	
24. FUNERAL DIRECTOR <b>Bradshaw Funeral Home, Crisfield, Md.</b>				23d. LOCATION (City or Town) (County) (State) <b>Marion, Md.</b>		22. DATE SIGNED <b>February 23, 1967</b>	
25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 28 1981

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